Objectives

- *Coding & Efficiency*
- *GME*
- *MAPPG 2006 Authorizations*
- *Cost Savings*

ENT, we have a problem…

- **Efficiency**
  - Speed of chart completion
 - Process of chart "flow"
- **Coding**
  - Getting credit for what a doctor performs through an intermediary who independently verifies chart documentation.

Problem 1: Efficiency

- Two grading scales
  - Timeliness @ 3 days
  - Completeness @ 23 days
- Random snapshots in time can show very different pictures of clinic timeliness
- Chart flow
  - Coders have 48 hours to finish their work
  - This leaves physicians only 24 hours to sign charts if they arrive on time

Chart Flow

- Chart should move in nice laminar flow, not in vortexes.
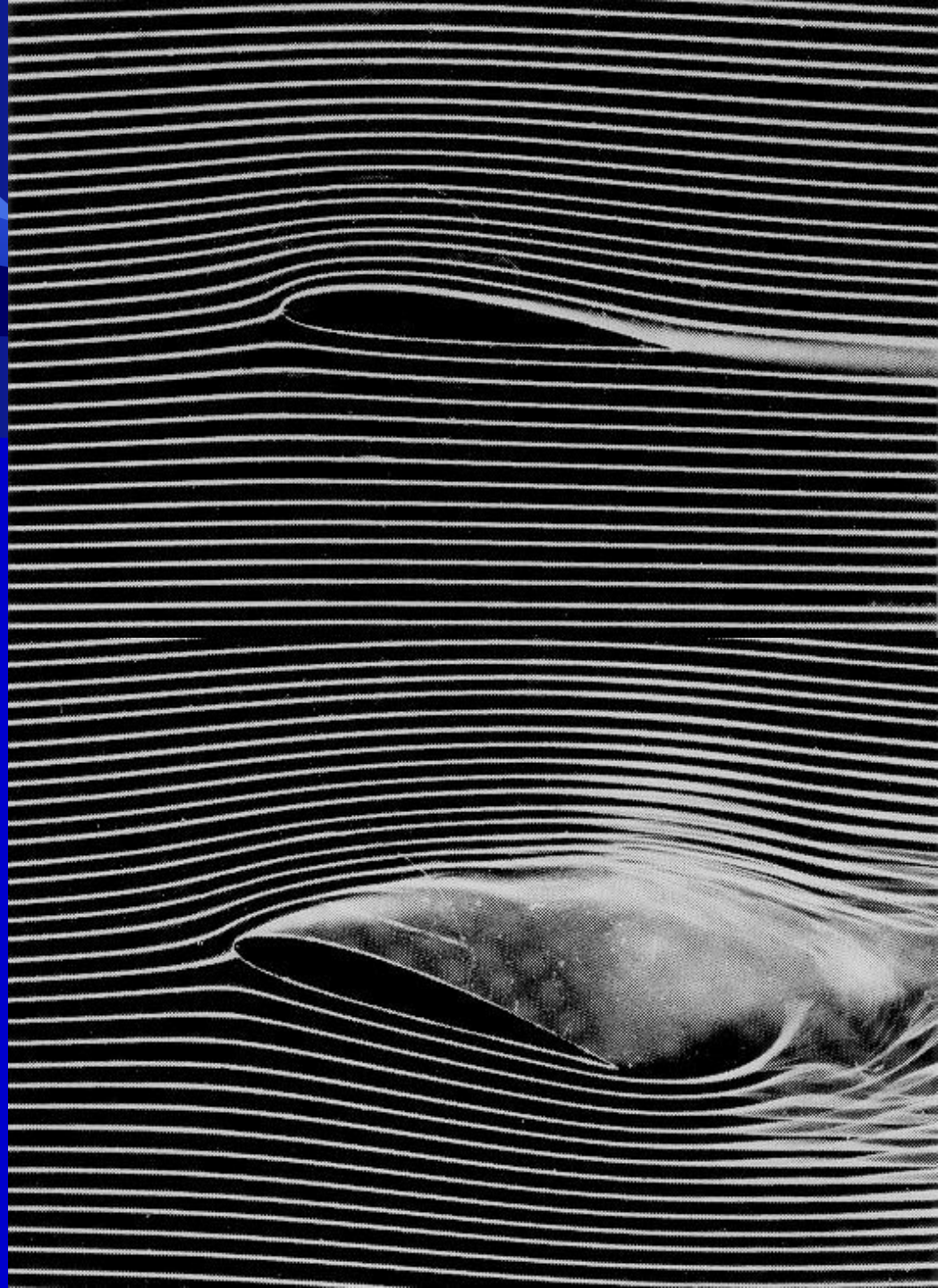
Problem: The Vortex

- **Unsigned charts**
  - Theoretically unacceptable
  - Situations arise when charts cannot be signed immediately:
    - Attending called away to OR
    - Patients are walk-ins and attending not immediately available
    - Continued care requirements exist after the clinic visit requiring the use of the chart
      - Pre-ops
      - Tumor patients
      - Interesting patients

Problems: in-depth

- **Unsigned charts**
  - Our clinic is built so that staff only have 2 clinics per week. If charts remain in clinic awaiting signatures, this easily creates a situation where charts exceed time-limits for efficiency
  - Clinicians who fail to sign charts and then go on TDY or leave create long delays

Problems: in-depth

- **Unsigned charts**
  - Residents commonly take charts out of clinic to review pre-ops, prepare for tumor board, and to follow up on issues
  - Staff also have charts delivered to their desks to review patient information prior to calling them, and for other clinical issues

The Solution

- **Efficiency is partly out of our control.**
  - Coders have 48 hours to finish their work, but if they are late, this still reflects adversely on the clinic.
  - It would be best to re-define efficiency as time chart takes to get TO coder, not BEING coded
- **Charts signed immediately**
  - Late Tech will be assigned to get all charts signed at the end of the day. This might include phone calls to "pester" staff about signing charts
  - Responsibility for getting charts signed ultimately lies upon physicians.
- **Charts leaving clinic**
  - ENT needs a copier to eliminate this problem

Problem 2: Coding

- Doctors unfamiliar with coding requirements
- Doctors have no incentive to increase coding level
- Coders are required to service multiple subspecialty clinics
- Coders are not trained in specialty prior to being assigned to our clinic
- There is no assigned backup coder so that effective cross-training can occur

Problems in depth

- Doctors are willing to participate and attempt good coding if it is not a cumbersome system.
  - Patient care should be the focus, not the distraction.
  - Redundant systems (i.e. dictating and writing notes) cannot stand the test of time and efficiency in today's world.
- Coders
  - Turnover is high for coders
  - Specialty training would seem obvious, but is not occurring.

Solution

- Need "Dummy Proof" system of medical record keeping that solves both problems with doctors and coders.
- Does not require doctors to stay up to date w/ basic coding knowledge.
- Does not require coders to be independently trained in subspecialty of clinic.
- Specialized SF600 developed by Derm is good start, but not enough
  - Lacks Medical Decision Making component
  - Consists of 1/3 E/M credit

Creating a Specialized SF600

- Asked my coder to contact her auditor and provide a coding sheet specialized for ENT.
  - Returned with Ears, Nose, Throat Examination Worksheet from Iowa Foundation for Medical Care
- Based on this form a specialized SF600 can be easily created for each clinic.

Coding Basics 101

- E/M (evaluation and management) codes
- 3 components
  - History
  - Exam
  - Medical Decision Making
- Level of coding based on appropriate documentation
- Best explained through chart:

Coding Chart

Visit type:	# E/M components evaluated
Office, new patient	3
Office, consult	3
Office, established	2

Outpatient - New (top) & Consults (bottom)					Established				
Requires 3 components per level					Requires 2 components per level				
Hx	1	2	3	4	4	Does not require MD	1	2	3	4
Exam	1	2	3	4	4		1	2	3	4
MDM	1	1	2	3	4		1	2	3	4
Time (min)	10 15	20 30	30 40	45 60	60 80	5	10	15	25	40
CPT	99201 199241	99202 299242	99203 99243	99204 99244	99205 99245	99211	99212	99213	99214	99215

ENT SF600

- All 3 E/M components
- Explicit coding instructions for doctors and coders
- List of procedures
- KISS

CC:
HPI: (Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, Associated Sx's/Signs)
Coding Info: PF, EPF: 1-3, DET, COMP 4+

Allergies:

Complete ROS: (CIRCLE systems discussed: EXPLAIN abnl findings only): Fever/Chills   Fatigue   Wt. Loss   N/V   Skin   ENT   Eyes   CV   Pulm.   GI   GU   Neuro   Musculoskeletal   Heme   Psych   Endo   Immun/Allergy
Coding Info: PF: 0, EPF: Related System (1), DET: 2-9 Systems, COMP: 10+ Systems

PMHx:

EXAM: *Coding Info: PF: 1-5, EPF: 6-11, DET: 12, COMP: ALL*
Nl   Abnl If checked, must document the specific pathological findings
- • General Appearance
- • Skin, Pinna & Nose
- • TM (L/R), EACs
- • Tuning Forks
- • Tonsils, Post. pharynx
- • Skin, Face/Neck
- • Anterior Rhinoscopy
- • Nasopharynx
- • Oral Cavity (lips, teeth, gums)
- • Oropharynx (mucosa, palate, tongue)
- • Hypopharynx/Larynx
- • Lymphatics (neck)
- • Neck
- • Thyroid
- • Lungs
- • CV
- • Neuro (CNs)
- • Eyes

PSHx:

FHx:

MEDICAL DECISION MAKING:
DATA: *Coding Info: SF: 0-1, LC: 2, MC: 3, HC: 4 (viewing image worth 2x value)*
Rpt View
- • CT scan _____
- • MRI _____
- • Audiogram:
- • Vestibular Battery
- • ABR
- • Path Result: _____
- • U/S: _____
- • Sestamibi scan
- • Labs: _____

SHx:
Tob: Y/N
Drugs: Y/N
EtOH: Y/N

Coding Info: PF, EPF: 0 DET: PFSH 1 COMP: PFSH 2-3

IMPRESSION & PLAN: *Coding Info: (risk of comps) SF: min, LC: low, MC: mod, HC: high*
Coding Info (# & significance of diagnoses) SF: 1 minor, LC: 2 minor, MC: 3 minor or new problems w/u, HC: 4 minor or new problem w/ add. w/u planned

Procedures
- • Flex Scope (nasal)
- • Rigid Nasal Scope
- • I&D:_____
- • Biopsy:_____
- • Trach Change
- • Nasal Packing
- • Nasal Cautery
- • Injection:_____
- • Removal F.B.:____
- • Cerumen removal
- • Mastoid cleaning
- • Myringotomy
- • PET
- • Epley Maneuvers

Coding Realities

- *Average appointment time for ENT patient is 15 minutes*
- *Expected time involved with a level 1 outpatient consult is 15 minutes*
- *To achieve a level 3 or higher visit is expected to require 30 to 80 minutes*
- *The expectation on our clinic w/ average appointments at 15 minutes should be an overwhelming majority of visits coded at levels I & II*
- *If past performance suggests higher standards, be highly suspicious of over-coding*

Coding example

- **It is relatively simple to go from a level 1 new visit to level 2.**
  - Requires asking about 1 ROS component
  - Requires evaluating 6 parts of Exam (as opposed to 1-5).

RVUs

- How much is a procedure or visit worth?

- Answer is Relative Value Units

- Is it really worth all the effort to obtain all that extra information from patients just to up-code a little, i.e. if time = money, does the increase in time necessary justify the extra work?

RVU fundamentals

- Resource Based Relative Value Scale developed by medicare in 1992.
  - Replaced customary charge fees
  - Based on relative value of services and resources they consume
- Three components are considered
  - Amount of **physican work** (~55% total value)
  - **Practice expense** associated with the service (42%)
  - **Professional liability** or malpractice expense (~3%)
- RVs then multiplied by Geographic Practice Cost Indices (**GPCI**s) for each medicare locality
- The total relative value is converted into a dollar amount by multiplying by an annually adjusted conversion factor ($37.3374 per each 2004 RVU).

RVU calculation

- Example: Level 3 office visit RVUs (CPT 99213)

Work	Practice Expense	Malpractice
0.67	0.70	0.04

- For San Antonio GPCIs are:

Work	Practice Expense	Malpractice
1.000	0.880	1.047

RBRVS continued

- **So multiplying each column in our example leads to:**

	Work	PE	Malpractice
RVUs	0.67	0.70	0.04
GPCIs	1.000	0.880	1.047
Total	0.67	0.616	.0419

- **Add the totals and this gives the total RVU for a level 3 office visit for our region**
  - **RVU = 1.3279**

- **Multiplying by the Medicare CF would show its dollar value:**
  - **1.3279 x $37.3374 = $49.58**

RVU comparisons

Visit Type	CPT	Level	Time	Total RVU	Total $	$/minute
New	99201	1	10	0.61174	$22.84	$2.28
	99202	2	20	1.22442	$45.71	$2.29
	99203	3	30	1.8671	$69.71	$2.32
	99204	4	45	2.75044	$102.68	$2.28
	99205	5	60	3.65258	$136.36	$2.27
OP consult	99241	1	15	0.88595	$33.08	$2.21
	99242	2	30	1.80997	$67.57	$2.25
	99243	3	40	2.40004	$89.60	$2.24
	99244	4	60	3.55712	$132.80	$2.21
	99245	5	80	4.71013	$175.85	$2.20
Established	99211	1	5	0.23327	$8.71	$1.74
	99212	2	10	0.61174	$22.84	$2.28
	99213	3	15	0.92308	$34.46	$2.30
	99214	4	25	1.50435	$56.16	$2.25
	99215	5	40	2.42576	$90.56	$2.26

Solutions

- "Dummy Proof" customized SF600
  - Can be printed on triplicate
  - Clearly defines components necessary to code at certain levels
  - Has all common procedures on it
- Patients help complete medical record in waiting room
  - Doctor reviews it with patient
  - Coding levels increase without any extra work
- Coders need to be familiar with specialties they cross-cover
- Lost revenue for ear cleanings will now be captured

GME Problem

- *Pre-Balad case numbers were adequate*
  - *50th percentile of the national average*
  - **35th percentile for Head and Neck Oncology**
- *Further reductions are a red flag for residency review committee!*
- *OR starts have diminished from 30 to 22 per month since Balad deployments – a 27% reduction*
  - *This trend must be reversed!*

GME Potential Solutions

- *Outsource anesthesia and nursing to ASU to reduce surgical waiting lists and increase case volume*
  - *APV over 65 patients are approximately 6 per month*
- *Combine residency programs with UT*
  - *WHMC is the only ENT training facility for USAF*
  - *Unique teaching environment necessary for Air Force ENTs*
  - *Long term leadership dilemma*

GME Ideal Solution

- *Have faculty and residents start their own service at the Audie Murphy VA Hospital*
  - *Our reconstructive surgeon with SAUSHEC residents will perform cases with UT faculty/residents at the VA*
  - *This step is a beginning towards an independent team*
  - *UT at this time is resistant to an independent military team*

Manpower Problems in MAPPG 2006

- *Eliminated a military ENT physician (7 to 6)*
  - *A loss in ENT physicians causes a loss in technician support*
  - *7 critical subspecialties are required to support GME*
  - *Mobility – WHMC represents all AF ENT deployment*
  - *TriCare Access standards – busted*
  - *7th ENT vital for any VA support*
- *Eliminated a civilian contract nursing position*
  - *Tumor board - not sustainable*
  - *Cochlear implant program – not sustainable*
  - *Conscious sedation in minor OR – not sustainable*
  - *Resident GME research – not sustainable*
  - *Patient teaching – not sustainable*

Manpower Solutions to MAPPG 2006

- *1 PA position (active duty) is authorized for 2006*
  - *This position is being converted to an ENT physician to bring the total ENT surgeons back to 7*
- *Maintain Civilian Contract Nurse*
  - *Tentative plan is to transfer one PA contract position from CT surgery to ENT to fill contract nurse position*
  - *Revise MAPPG*
  - *Outside funding source (to be discussed....)*

Problem: Sleep Studies #1 Leak for Lackland

- *Constitutes nearly one half of all outpatient prime leakage*
- *$20K – $30K each month!*
- *WHMC sleep lab saturated*
  - *Services active duty patients only*
  - *All others leak out*

Solution: Alternatives

- *Expand sleep lab facilities at WHMC*
  - *Demand too great*
  - *Inadequate facility space and staff*
- *Denial of service*
  - *Undiagnosed/untreated risks too high*
    - *MI, stroke, HTN*
- *Portable home sleep study*

Solution: Portable Sleep Study

- *Validated as accurate as sleep study*
- *Provides necessary information to treat OSA*
- *High patient compliance and satisfaction*
- *Cost savings:*
  - *Traditional sleep study ~$750*
  - *Home study ~$250*
  - *Cost savings of $12K - $20K per month*
- *Not medicare reimbursable, but it is FDA approved*
  - *Primary sleep study for Kaiser and VA groups*

Problem: Savings Windfall!

- *Solutions:*
  1. *Copier needed in ENT clinic to aid in coding & efficiency*
  2. *New funding available for ENT contract clinic nurse*
  3. *Need for additional ENT clinic microscopes and video towers*
     1. *Current clinic microscopes are greater than 10-15 years old (life expectancy of 10 years)*
     2. *Remain on unfunded list for 2 years*

Review

- *Coding Efficiency*
- *GME*
- *MAPPG 2006 Authorizations*
- *Cost Savings*